MONTANA
Department of Public Health & Human Services

January 15, 2007
Montana Medicaid Notice
Inpatient Hospitals

Inpatient Out-of-State Hospital Changes

To ensure Medicaid client access to services unavailable in Montana—such as transplants, treatment for cancer, burns, or trauma, or neonatal and pediatric surgical services—the Department has developed two different payment methodologies and new prior authorization requirements for out-of-state inpatient hospital services. Facilities will be designated as either preferred or non-preferred.

These changes were effective for claims with dates of service beginning January 1, 2007. Residential Treatment Facilities are exempt.

Preferred out-of-state hospitals are those located more than 100 miles outside Montana's borders that have signed an agreement with the Department to provide specialized services and have provided a Medicare cost report to the Department. When prior authorization has been obtained, these facilities will be paid by hospital-specific Medicaid inpatient cost-to-charge ratios and cost-settled. Reimbursement without authorization will be at the in-state Diagnosis Related Group (DRG) rate and will not be subject to cost settlement. Acute care psychiatric hospitalizations always require prior authorization.

A copy of the "preferred hospital" agreement follows this notice for review and consideration.

Non-preferred hospitals—those that do not sign an agreement with the Department—will be treated as Prospective Payment System (PPS) facilities, reimbursed using the in-state DRG methodology, and will not be cost-settled. Services provided by these facilities will no longer require prior authorization except for acute psychiatric hospitalizations and services that normally require prior authorization, such as gastric bypass, transplants, etc.

For assistance in deciding to become a preferred hospital, providers can find the DRG fee schedule at http://medicaidprovider.hhs.mt.gov/providerpages/providertype/01.shtml#feeschedules. Click "Current Fee Schedule" and review the most current version. To review the applicable Montana Administrative Rule (MAR), go to www.dphhs.mt.gov, click on Programs & Services, Legal Resources, and Rule Proposals to find the rule (MAR 37-395 / 11/3/06) on pages 10-11 (37.86.2905).

Providers who want to become a "preferred hospital" should sign the agreement and submit it with their required cost report to:

Mary R. Patrick, R.N., M.Ed., Hospital Case Manager
Hospital and Clinic Services Bureau

Montana Medicaid
1400 Broadway / P.O. Box 202951
Helena, MT 59620-2951
Fax: (406) 444-1861
E-mail: mpatrick@mt.gov

If you have trouble accessing the above information or have questions, please contact Mary Patrick at (406) 444-0061.

Contact Information

For claims questions or additional information, contact Provider Relations:

Provider Relations toll-free in- and out-of-state: 1-800-624-3958
Helena: (406) 442-1837

Visit the Provider Information website:

http://www.mtmedicaid.org

MEMORANDUM OF AGREEMENT FROM THE MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

PREFERRED HOSPITAL AGREEMENT

This Memorandum Of Agreement (MOA) is entered into between the Health Resources Division of the Montana Department of Public Health and Human Services (hereinafter referred to as the "Department") whose address and phone number are 1400 Broadway, P.O. Box 202951, Helena MT 59620, (406) 444-0061 and (Hospital Name) _____ (hereinafter referred to as the "Facility"), whose Federal ID number is _____, mailing address is_____, fax number is _____, and phone number is _____. (The Facility contact name and number) _____ from the Facility and Mary Patrick at 406-444-0061 from the Department serve as the primary contacts between the parties regarding the performance of this MOA.

PURPOSE OF AGREEMENT:

A. The purpose of this MOA is for the Facility to receive cost reimbursement contingent upon prior authorization for Montana Medicaid client inpatient admissions. Without prior authorization, the Facility will receive DRG reimbursement. Without authorization for psychiatric admissions, the Facility will receive no reimbursement.

B. This MOA details the process by which the Facility will:

1. Qualify as a "Preferred Hospital";
2. Requirements necessary to receive the "Preferred Hospital" reimbursement rate;
3. Results of not meeting requirements as a "Preferred Hospital"; and
4. Explanation of reimbursement methodology.

C. Montana Department of Public Health and Human Services (DPHHS) is the Montana state agency responsible for the administration of the Montana Medicaid program.

DEFINITIONS:

A. Annual Medicare cost report – is the official Medicare cost report (Form CMS 2552-96) which the hospital files annually with the Medicare Federal Intermediary.

B. Cost reporting period – the period for which the cost report is being filed, which is usually the hospital's fiscal year.

C. Cost settled – a retrospective review of the interim payments made to a hospital. These payments are compared to the actual hospital costs for providing services to a Medicaid client, based on the hospital's cost report. After review, the Department will either make additional payments to the hospital if the interim payments are less than hospital costs or recover any interim payments which exceed the hospital costs for services provided.

D. Hospital specific cost-to-charge ratio on the interim – means interim payment rates established by comparing the individual hospital's inpatient charges to inpatient costs. Capital and medical education costs are included in this interim rate. The Department will use the hospital's most recently filed or settled cost report to determine these rates. This rate will be used by the Department to reimburse appropriately filed claims on the interim.

E. Preferred Hospital – as defined in Administrative Rules of Montana (ARM) 37.86.2901 means a hospital located more than 100 miles outside the borders of Montana that has signed a memorandum of agreement with the Department to provide specialized services that have received prior authorization by the Department and has provided a cost report to the Department.

F. Prior authorization – as defined in ARM 37.86.2901means authorization by the Department to perform medically necessary services before the services are provided. Prior authorization is obtained from the Department or its designated utilization review organization. Once the utilization reviewer determines that a hospital admission is medically necessary and services may be provided outside of Montana, an authorization number will be provided to the Facility to include on all claims submitted for adjudication. To obtain prior authorization for medical hospital admissions, please call Mountain-Pacific Quality Health Foundation at 1-800-262-1545 ext. 5850. For mental health hospital admissions, please call First Health Services at 1-800-770-3084.

RESPONSIBILITIES:

A. The Facility agrees to do the following to become a "Preferred Hospital" status (as defined in ARM 37.86.2901 "Inpatient Hospital Services, Definitions") and to receive cost-based reimbursement:

1. Sign this agreement with the Department to be reimbursed hospital specific cost- to-charge ratio on the interim and to be cost settled;
2. Before a non-emergent inpatient admission, obtain prior authorization from the Department or its designated utilization review organization. Prior authorization allows the Department to verify that the service or services are medically necessary and are either not available in state or an instate specialist has declined to perform the service or services. After an emergent inpatient admission, obtain prior authorization within 2 business days of the admission (Monday through Friday);
3. Submit an annual Medicare cost report in which costs have been allocated to the Montana Medicaid program as they relate to charges. Submit this report at the time of this agreement and annually thereafter if prior authorized services have been performed in that year;
4. Maintain appropriate accounting records which will enable the facility to fully complete the cost report;
5. File the cost report with the Department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period; and
6. Abide by all other medical provider rules and regulations, including to but not limited to the provider enrollment form, the provider manual, and the Administrative Rules of Montana.

B. The Department agrees to do the following:

1. Process the signed agreement and cost report and initiate applicable reimbursement methodology for “Preferred Hospital” status;
2. Provide for hospital specific cost-to-charge ratio on interim and cost settle;
3. Except for inpatient acute psychiatric hospitalizations which always require authorization, reimburse instate DRG payment without cost settlement when prior authorization is not obtained; and
4. Be available to assist the Facility with the coordination of admission, transportation, and any other authorizations necessary for these services.

Inpatient acute psychiatric hospitalizations will not be reimbursed without authorization.

COMPLIANCE WITH APPLICABLE LAWS, RULES AND POLICIES:

The Facility and the Department must comply with all applicable federal and state laws, executive orders, regulations and written policies, including those pertaining to licensing.

MOA TERMINATION:

Either party may terminate this agreement without cause. The party terminating this agreement must give notice of termination to the other party at least 30 days prior to the effective date of termination. Notice of termination must be given in writing.

The Facility, after termination of this MOA, remains subject to and obligated to comply with all legal and continuing MOA obligations arising in relation to its responsibilities that may arise under the MOA including but not limited to, record retention, audits, submitting cost report if requested, and the protection of confidential information.

CHOICE OF LAW, REMEDIES AND VENUE:

A. This MOA is governed by the laws of the State of Montana

B. Any remedies provided by this MOA are not exclusive and are in addition to any other
remedies provided by law.

C. In the event of litigation, venue must be in the First Judicial District in and for the County
of Lewis and Clark, State of Montana.

TERM:

The term of this MOA begins at the time this agreement is signed and approved by the Department and continues as long as all parties abide by the terms of this agreement. The Facility may request begin date to be backdated if the Department agrees. This agreement is not in effect for claims with admission date prior to January 1, 2007.

The parties through their authorized agents have executed this MOA on the dates set out below.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

By: _____ Date _____
Mary Patrick, R.N., Hospital Case Manager
Department of Public Health and Human Services
Human Resources Division
Montana Medicaid – Hospital and Clinic Services Bureau
1400 Broadway, P.O. Box 202951

Helena, MT 59620-2951
406-444-0061

By: _____ Date _____

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Facility contact name, address & phone #